Erie St. Clair **LHIN**

A Snapshot of Local Health Care

Erie St. Clair Local Health Integration Network

Annual Report 2015-16

For the year ending March 31, 2016

Ontario
Local Health Integration Network

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Message from the Board Chair and CEO

All we see of someone at any moment is a snapshot of their life, there in riches or poverty, in joy or despair. Snapshots don't show the million decisions that led to that moment.

– Richard Bach

These words ring especially true for Ontario's health care system.

Too often, we see the health care system in a series of "snapshots": moments of excellence, and moments when we could have done better. The truth, however, lies somewhere in between: through looking critically at the snapshots, and then trying to learn and understand what worked well, and where could we improve.

Understanding what worked, and what didn't, is a key focus for the Erie St. Clair Local Health Integration Network (LHIN). Our role as planners, managers, and funders of the health care system means that we must thoroughly understand what is happening in health care locally.

We do this in many ways, but some of the most important information we receive is from those within the system: health care providers, front-line staff, health care organizations, and, most importantly, patients. Patients and their families help us to make sense of our snapshots, let us know what worked and what isn't working, and tell us how the system needs to transition.

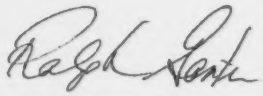
The benefit of LHINs is that we are local: We understand the health care needs of our residents, and we reach out to those who have firsthand experience and knowledge — the patient and those who care for patients.

As we work toward our vision of "Better Care, Better Experience, Better Value," we know that we cannot do it alone. Our work is strengthened by the collaboration and hard work of those who tirelessly care for patients every day. We thank all of our partners for another year of incredible collaboration and the collective willingness to make health care better in Erie St. Clair.

We encourage you to learn more about the Erie St. Clair LHIN, the ways you can provide input, and initiatives that are helping to improve local health care.

Sincerely,

Martin Girash, Board Chair



Ralph Ganter, Acting CEO

Introduction to the Erie St. Clair LHIN

The ESC LHIN is one of 14 Local Health Integration Networks in Ontario. The LHINs were established in 2006 to manage the planning, integration, performance, and funding of the health care system. This responsibility includes services delivered by:

- hospitals
- long-term care (LTC) homes
- Community Care Access Centres (CCACs)
- community support service (CSS) agencies
- mental health and addictions agencies
- community health centres (CHCs)

Population Health Profile

The health service needs of Erie St. Clair residents are significantly different from those of Ontario as a whole. Compared to the province, Erie St. Clair has:

- a higher number of people living on low incomes
- a population with a lower life expectancy
- a higher proportion of seniors
- a higher incidence of individuals who are overweight
- a higher proportion of individuals with poor lifestyle habits such as smoking, drinking, poor nutrition, and inactivity
- higher rates of chronic conditions such as cardiovascular diseases, cerebrovascular diseases, diabetes, high blood pressure, chronic obstructive pulmonary disease (COPD), and arthritis

For more detailed information on Erie St. Clair's population health care utilization, or demographic information, see *ESC LHIN's Integrated Health Service Plan 4 – 2016-2019* (IHSP) at http://www.eriestclairlhin.on.ca/Accountability/IHSP/IHSP4-2016-2019/IHSP 4 - 2016-2019.aspx.

Service Area

The ESC LHIN serves approximately 636,000 people in the regions of Chatham-Kent, Sarnia/Lambton, and Windsor/Essex (see Figure 1). Although these regions are independent, and each has unique qualities, they also share many commonalities, such as being surrounded on three sides by the Great Lakes. The area's urban-rural mix is economically dependent upon the agricultural, petrochemical, and automotive industries. As well, the region's American neighbours not only influence the local economy and trade, but also affect the use and perception of health care.

Windsor/Essex comprises 63% of the population; Sarnia/Lambton, 20%; and Chatham-Kent, 17%. The population includes immigrants (16.9%), seniors (18.4%; those aged 65+), Francophones (3.3%), and Indigenous peoples (2.5%).

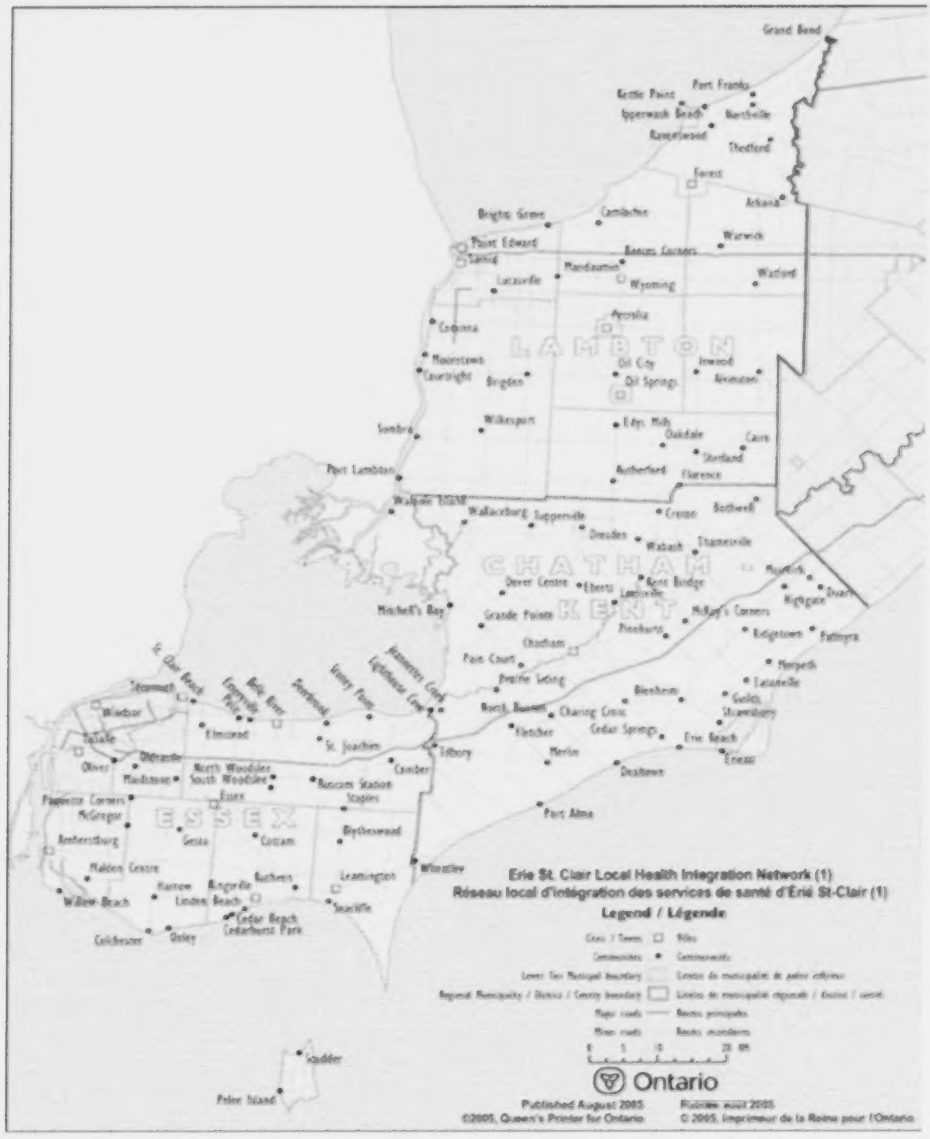


Figure 1: Map of the Erie St. Clair LHIN Region

ESC LHIN Initiatives

Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario was released by the Ontario Ministry of Health and Long-Term Care on December 17, 2015. This document outlines a new perspective on health care, one that engages health care providers (HCPs) with their communities. Although the document's proposal is still in the discussion phases, it points to

the possibility of significant health care transformation across Ontario, and in the Erie St. Clair region.

In alignment with the Ontario government's current vision for health (*Patients First: Action Plan for Health Care*), the IHSP 4, and ESC LHIN's *Annual Business Plan 2015-2016*, the LHIN undertook a number of strategic initiatives this year in order to move toward achieving its vision of "Better care, Better experience, Better value" for the residents of Erie St Clair.

Ontario's LHINs are required to submit and post an annual business plan each year and an IHSP every three years. The annual business plan outlines the key local priorities and initiatives for each year, whereas the IHSP provides a three-year strategic vision and direction for health care in each LHIN's region. Erie St. Clair LHIN's annual business plan and the IHSP highlight several key areas for continued improvement, including improved outcomes in:

- emergency departments (EDs)
- alternate level of care (ALC)
- chronic disease management
- mental health and addictions
- rehabilitation care
- hospice palliative care
- Francophone health care
- Indigenous health care

The following sections outline the progress made in key initiatives throughout the 2015-16 fiscal year.

Emergency Department Care

The ED is often the most-visited area of any hospital. It is a place that must be available when people need it most.

Addressing wait times in the ED continues to be an area of priority for the ESC LHIN. Wait times are a complex challenge with no single solution. It takes the collaborative efforts of patients, physicians, nurses, clinicians, administrators, community partners, and patients to make ongoing, incremental improvements.

The ESC LHIN continually measures key indicators and makes adjustments to ensure that wait times in our region are improving. Once it is understood which changes are working well, and which are not, the areas in need of greatest improvement can be focused on and the results can be measured. For example, Ontario's pay-for-performance program, which uses process-improvement strategies in hospitals — monitored through key indicators — to improve performance, is a proven way to reduce wait times in the province.

Areas of continued focus for ED improvement by the ESC LHIN include:

- shorter wait times
- patient flow throughout the health care system, in order to improve wait times
- individualized discharge plans created in collaboration with care partners

Key initiatives undertaken in 2015-16 to improve wait times included:

- enhanced physician hours at peak times
- improving patient flow for high-acuity admitted patients
- implementing a pay-for-performance program
- improving the triage process by increasing the opportunity for physicians performing initial assessments and triaging patients as soon as possible
- avoiding admission to the hospital by investing in community care
- continuing to invest in chronic disease management programs, such as the Breathe Well COPD Program, that improve health outcomes and reduce hospital usage
- implementing rapid assessment zones (RAZs) and clinical decision units (CDUs), which allow for short-term monitoring, investigation, and treatment to support the philosophy of "right place, right time, right care," and avoid unnecessary admissions to the hospital

The ED plays an important role in our health system, but it is also important to ensure that community and primary care options are available to address non-urgent needs. By focusing on linkages with primary care, improving chronic disease management, and increasing timely access to mental health and addictions care, the ESC LHIN is ensuring that care options are available for those for whom the ED is not the most appropriate place for care.

Ten of the 16 indicators for stroke performance in the ESC LHIN this year showed a clear trend toward progress. Some facilities were high performers in this area, especially Chatham-Kent Health Alliance (CKHA) and Bluewater Health.

The largest opportunity for improvement lies in the implementation of stroke-unit care and improved access to inpatient rehabilitation. The Southwestern Ontario Stroke Network (SWOSN) continues to work with the ESC LHIN and other health system partners on the realignment of stroke care to designated stroke centres with stroke units. SWOSN also provides community stroke rehabilitation and supports the implementation of the ESC LHIN stroke care pathway, focusing on access to inpatient rehabilitation and the need for high-intensity, stroke-specific outpatient/community rehabilitation across the LHIN.

One site, Bluewater Health, continues to participate in the Ontario Telestroke Program, an emergency telemedicine application that provides emergency physicians with immediate access to neurologists who have expertise in stroke care and can support both the assessment and the treatment of patients experiencing acute ischemic stroke symptoms. Using teleradiology to review computerized tomography (CT) images and videoconferencing solutions, an off-site neurologist can assess patients and recommend whether they are candidates for thrombolysis and other acute-stroke interventions. Administration of the thrombolytic (clot-busting) agent tPA (tissue plasminogen activator) requires a physician with expertise in stroke management, because the drug must be administered as soon as possible within the first 4.5 hours after the onset of a stroke.

Alternate Level of Care

Providing the right care in the most appropriate setting is the goal of all care providers. When patients cannot access the care setting they need, the situation is referred to as ALC: that is, needing an alternate level of care setting that is not available at that time. Being designated ALC essentially means that someone is being provided care in a hospital when he or she would be better served in another care setting.

Improving ALC benefits everyone. Patients receive care in the most appropriate care setting, wait times are reduced, and patient flow through the health care system is increased. Alternate level of

care continued to be a key priority for the ESC LHIN in fiscal 2015-16. Advancement in this area has been due in part to:

- continuing to encourage health care providers to work together around discharge planning and to reinforce the importance of the Home First philosophy, wherein patients are supported at home while they are making life or care decisions
- managing patient and family expectations through early engagement, education, and ongoing discussions
- helping all health care providers gain a better understanding of how ALC is affecting hospital operations, both in acute and post-acute care
- helping partners have a better understanding of patients' needs, including where the gaps and opportunities are in the system, so that they can better support their patients
- using consistent messaging and processes and communicating better with patients and families. This will help patients be more comfortable with the decision-making process and better able to make informed care choices
- an investment by the ESC LHIN in 30 new rehab beds at Hôtel-Dieu Grace Healthcare (HDGH) and sub-acute care programs such as nurse-led outreach teams in Sarnia/Lambton and Chatham-Kent. These kinds of investments better support patients in accessing the most appropriate care

The ESC LHIN is continually working to improve ALC in our region, because improving patient flow through the hospital and reducing wait times benefits both patients and the health care system. ALC will therefore continue to be a key priority for the ESC LHIN in 2016-17.

Mental Health and Addictions

Mental health and addictions care continued to be a priority for the ESC LHIN in 2015-16 (see Table 1). Investments were made in alignment with the five strategic pillars of the November 2014 update to MOHLTC's 10-year mental health and addictions plan, *Open Minds, Health Minds*:

1. Promote resiliency and well-being in Ontarians
2. Ensure early identification and intervention
3. Expand housing, employment supports, and diversions and transitions from the justice system
4. Provide the right service, at the right time, in the right place
5. Fund based on need and quality

Although improvements and investments were made during 2015-16, access and community-based treatment are continued foci through the ESC LHIN's Mental Health and Addictions Network.

Table 1: Mental Health and Addictions: New Investments in the ESC LHIN, 2015-16

Health Service Organization	Program	2015-16 Funding
Bluewater Health	Clinical Pathways and Transitional Support	$75,000
Brentwood Recovery Home	Salvation Army — Homeless and Addicted Men's Program	$15,000
	Youth Adults Addictions Day and Residential Program	$150,000
Canadian Mental Health Association Lambton-Kent	Mental Health Awareness and Literacy	$120,000
	Rapid Assessment Intervention Treatment Program	$219,225
Canadian Mental Health Association Windsor-Essex	Release from Custody Program	$32,625
	Vocational Peer Support	$12,500
Chatham-Kent Health Alliance	Clinical Pathways and Transitional Support	$200,000
Windsor Regional Hospital via Chatham-Kent Health Alliance	Resident Assessment Instrument Emergency Screener	$50,000
Long-Term Care Homes (Behavioural Internal Champtions)	Behavioural Supports Ontario – Complex Behaviours	$96,042
Sexual Assault Crisis Centre of Essex County	IT software needs	$29,500
Ten Friends Diner	IT software needs	$8,898
Westover Treatment Centre	Operational pressures	$31,460
TOTALS:		**$1, 040, 250**

In addition to the investments outlined in Table 1, the ESC LHIN focused on improving access to care in the addictions sector by developing an addiction strategic plan. This plan included a robust community engagement process in which feedback and input from 900 people were received. Feedback from care providers, those with addictions, family members, and other key stakeholders was incorporated into the final plan.

The addiction strategic plan received endorsement from the ESC LHIN board in March 2016. Staff will continue to work with our service providers to implement the recommendations contained in the addiction strategic plan.

Chronic Disease Prevention and Management

Five percent of people consume 66% of health care spending in Ontario because of the complexity of their medical conditions; this is true both in the province as a whole and in Erie St. Clair. Statistics such as this provide clear evidence that we can do a better job delivering more coordinated care. To achieve this goal, in 2015-16 the ESC LHIN focused on improvement through better care coordination, enhanced care quality, and the development of evidence-based care pathways.

Compared to the rest of the province, the Erie St. Clair population has higher rates of:

- arthritis
- asthma
- diabetes
- hypertension
- mood disorders
- chronic obstructive pulmonary disease (COPD)
- congestive heart failure (CHF)
- heart disease

Of these conditions, the largest proportions of ED visits are associated with arthritis, heart disease, and COPD.

To better prevent and manage chronic diseases, the ESC LHIN continued its work on the implementation of regional chronic disease and prevention management care pathways and service delivery models. Key initiatives in 2015-16 included:

- the advancement of a COPD integrated care logic model by the Chronic Disease Prevention and Management (CDPM) Physician Lead. The main objectives were to:
  - establish health service provider accountability to patients through improving access to care and incorporating the patient experience into planning and care
  - improve the health of COPD patients
  - better manage the costs of COPD care, thus ensuring a more sustainable system
  - promote innovation through best practice uptake
  - continue to build capacity through quality improvement
  - work collaboratively to ensure better access to primary care
- the continued promotion, development, and dissemination of key clinical pathways for diabetes care with relevant stakeholders and primary care providers
- the implementation of a standard central intake referral form to facilitate a smoother process to access diabetes services. This builds on the work of the former Diabetes Regional Coordination Centre.

By focusing on prevention and improved chronic disease management, people will live longer and experience a better quality of life.

Community Support Services

The ESC LHIN believes in the value of community-based health care and understands that people prefer to live in the community as long as possible, and to access care as close to home as they can. Because of the important role community services have in our health care system, the ESC LHIN continues to make investments in community-based care. New community investments in 2015-16 included the following programs:

- Assisted Living Southwestern Ontario: mobile support of daily living expansion
- Canadian Red Cross: Homeward Bound Program (Chatham-Kent)
- Erie St. Clair CCAC: Telehomecare expansion
- Victorian Order of Nurses Canada: Falls Prevention Program
- Community Support Centre of Essex County: new vehicles for LHIN-funded health transportation providers
- Alzheimer Society of Chatham Kent: Day Program
- North Lambton CHC: dedicated nurse practitioner (NP) for the CHF Program

The ESC LHIN provided approximately $1.1 billion in funding to 83 local health service providers; of these, 42 are community-based providers that received $260,128,374 in funding in 2015-16. This figure includes $3,025,400 in new community funding to address:

- community-based care needs
- LHIN-local priorities
- the expansion of community service capacity
- increased client acuity
- reducing ALC pressures
- Falls Prevention Program funding needs
- a needed increase in home care nursing services' maximum hours

For specific mental health and addictions investments, see Table 1.

Hospice Palliative Care

The ESC LHIN works with and supports the Erie St. Clair Hospice Palliative Care Network (ESC HPCN) and its members as they make improvements in local palliative care. This support enables the ESC HPCN to advance the goals set out in its 2015 strategic plan. Key improvement strategies included the areas outlined below.

Hospices

- Both Erie Shores (Leamington) and Chatham-Kent Hospices were under construction in 2015 in anticipation of planned openings in spring 2016. When opened, Erie Shores, a satellite of The Hospice of Windsor and Essex County, will be the first satellite hospice in Canada. The addition of these two new 10-bed hospices in 2016 will bring the total number of hospice beds available in Erie St. Clair to 38. Community support for the hospices has been outstanding.
- The Hospice of Windsor and Essex County and Sarnia St. Joseph Hospice continue to provide excellent care in residential beds and in community-based programs.

Compassionate Community

- Work continues on moving Windsor/Essex toward being designated an official "Compassionate Community." Significant progress has been made on work associated with the five pillars:
  1. Neighbourhood Study — using technology to help connect people and support the building of "neighbourhood" networks
  2. Distress Outreach — building a safety net so that those who really need help, get help
  3. Care Model Study — setting up Citizen's Care Hubs for vulnerable persons and people suffering with dementia
  4. Key Informant — strengthening and leveraging technology to help make Windsor-Essex a more caring and efficient community

5. Community Governance — working with all levels of government to set up a "Community Trust" based on population study, research, and strong partnerships

- The overall effort extends the reach and value of programs, services, and businesses that already exist in the community. All initiatives are guided by an overall vision: "Each of us, working together, to make ourselves, our citizens and our community, more well."
- In Chatham-Kent and Sarnia/Lambton, a review was completed on how to create community hubs, with each of the hospices serving that role for palliative care.

Palliative Care Education

- The ESC Hospice Palliative Care Education subcommittee and education collaborative continue to support capacity-building efforts that are aligned with the Erie St. Clair Hospice Palliative Care Network and Local Health Integration Network's *Hospice Palliative Care in Erie St. Clair Strategic Plan*, February 2015, through the coordination and provision of hospice palliative care education. In 2015-16, more than 1,000 people across Erie St. Clair took part in 37 education, communication, and research-related initiatives.

Provincial HPC Work and Structure

- ESC LHIN CEO Gary Switzer and Monica Stanley, Regional Vice President, Cancer Program, ESC Regional Cancer Program, were closely involved throughout 2015 in the development of the new Ontario Palliative Care Network (OPCN).

Palliative Care Consultation Teams

- Specialist-level palliative care consultation teams are available in all three counties in Erie St. Clair. A report based on a review of community-based hospice palliative care in Windsor/Essex was completed in 2015. Follow-up on the recommendations is underway.
- These teams, along with specialist physicians and teams from hospices, provide symptom management and support to patients and families in their own homes; together, they visit more than 1,600 patients annually.

Advance Care Planning and Health Care Consent

- A range of communication and education initiatives was undertaken to raise awareness and understanding of the importance of informed health care consent (HCC) and advance care planning (ACP) across Erie St. Clair. Work supported included education as well as efforts to strengthen HCC and ACP policies and processes in all sectors and settings.

The ESC LHIN is committed to ensuring that residents who have life-limiting illnesses have access to high-quality end-of-life care.

eHealth

TransForm Shared Service Organization (TransForm) Regional Project Management Office (PMO)

TransForm's Regional PMO saw approximately 50 high-complexity ehealth and technology projects roll out across the LHIN in 2015. The projects, which have included a telehomecare/telemedicine initiative, an investigation of area hospital information systems (HISs), and a care coordination tool developed for Chatham-Kent Health Alliance and Chatham-Kent Health Link, have contributed to enhancing the delivery of care by improving patient flow, reducing wait times, and improving clinical services.

ConnectingOntario and the Connecting South West Ontario (cSWO) Program

ConnectingOntario is a provincial initiative funded by eHealth Ontario that is making individuals' health information from across the continuum of care available at any point of care, and in a timely and secure fashion. In southwestern Ontario, it is being delivered by the cSWO Program, and four change management and adoption delivery partners. In Erie St. Clair, this responsibility belongs to TransForm, which, amongst other initiatives in 2015, successfully connected all of ESC's acute care hospital sites to both the Program's Regional Clinical Viewer, ClinicalConnect™, and to OntarioMD's Hospital Report Manager (HRM). Work also began at three hospitals (five sites) on the cSWO Program's Acute Clinical Data Repository (ACDR) pilot (the ACDR leverages local, regional, and provincial ehealth registries and repositories as data sources for clinical reports).

Integration

In 2015-16, the ESC LHIN continued to support integration activities through both formal integration processes and informal activities, such as increasing collaboration amongst health care providers. We are proud of the numerous partnerships that have occurred between LHIN-funded providers and other stakeholders. Increased collaboration amongst all providers ultimately ensures greater sustainability of the health care system and more coordinated care for patients.

Table 3 outlines the formal integrations that were completed during 2015-16.

Table 3: ESC LHIN Integrations, 2015-16

Date/Event	Organization/HSP	Motion
May 5, 2015, ESC LHIN open board meeting	**Expert panel — integration decision**	MOTION: Moved by Barb Bjarneson and seconded by Robert Bailey that the ESC LHIN Board approve the following: Pursuant to section 25(2)(b) and section 26 of the *Local Health System Integration Act, 2006,* the LHIN finds that it is in the public interest to require the Leamington District Memorial Hospital to proceed with the integration described in this decision and the Party is hereby required to implement the following by June 23, 2015: • To continue to provide obstetrics services. • To add five "Slow Stream Rehabilitation" beds at Leamington District Memorial Hospital. • To work with the LHIN and its partners in examining the new Navigation Centre model, as proposed by the Expert Panel, and the redesign of birthing services at Leamington District Memorial Hospital. • To develop a transition plan, communication plan, and operating plan for implementation in respect to this integration. Motion Passed

June 23, 2015, ESC LHIN open board meeting	**Leamington District Memorial Hospital (LDMH) — proposed integration decision**	MOTION: Moved by Joseph Bisnaire and seconded by Barb Bjarneson that the ESC LHIN Board continues to move forward with the proposed integration decision, as written. ESC LHIN staff also recommends the following supplemental actions: • That work continues on the development of the Navigation Centre with a target of receiving a briefing of the final model's structure and parameters of services within the third quarter (Q3) of the current fiscal year. • That, in the development of the Navigation Centre Model, a simulation exercise occur. The results and outcomes of the simulation exercise will be summarized in a readiness assessment report to be shared with the Board prior to the Navigation Centre's formal operation. • That ESC LHIN staff work with LDMH on the cost structure and care model of the obstetrics service in order that the service is more in line with the notional funding provided by Ministry of Health and Long-Term Care (MOHLTC) sources. • That ESC LHIN staff work with the MOHLTC on temporary financial support for the expansion of the slow stream rehabilitation beds until the impact of the expanded beds is fully recognized through the hospital's funding formula impact. Motion Passed
June 23, 2015, ESC LHIN open board meeting	**Life After Fifty (LAF) Services/Community Services of Essex County (CSCEC) — facilitated integration**	MOTION: Moved by Barb Bjarneson and seconded by Robert Bailey that the ESC LHIN Board approves the facilitated integration and transfer of transportation services from Life After Fifty (LAF) to Community Services Centre of Essex County (CSCEC), including program funding and assets (e.g., vehicles). Motion Passed
December 15, 2015, ESC LHIN special open board meeting	**Leamington Area Birthing Services — final recommendation**	MOTION: Moved by Michael Hoare and seconded by Joseph Bisnaire that the ESC LHIN Board requests the Windsor-Essex Community Health Centre (WE CHC) and the Leamington District Memorial Hospital (LDMH) to establish a formal partnership (e.g., Memorandum of Understanding) which will provide leadership oversight for birthing services in the Leamington and Area community, with WE CHC's primary focus being the Navigation Centre and the LDMH's primary focus being the birthing unit; and directs LHIN staff to request the Windsor-Essex Community Health Centre (WE CHC) and Leamington District Memorial Hospital (LDMH) to present their operational plan for the Leamington Area Birthing Services to the ESC LHIN Board in January 2016. Motion Passed

March 22, 2016, ESC LHIN open board meeting	**Chatham-Kent Community Health Centre (CK CHC), Canadian Mental Health Association Lambton-Kent (CMHA LK), and Chatham Kent Health Alliance (CKHA) — voluntary integration**	MOTION: Moved by Michael Hoare and seconded by Barb Bjarneson that the ESC LHIN Board supports the Chatham-Kent Community Health Centre: • Voluntary integration of leadership for counselling services and chronic disease management with Canadian Mental Health Association – Lambton-Kent and Chatham Kent Health Alliance respectively • Back office shared services integration for finance and decision support with Chatham Kent Health Alliance • Back office integration of human resources with Chatham Kent Health Alliance • Information technology/information management infrastructure integration with Chatham Kent Health Alliance and: It is recommended that the ESC LHIN Board takes no further action with regard to the integrations and allow the integrations to proceed consistent with objectives of the *Local Health System Integration Act, 2006*. Motion Passed

Health Links

A Health Link is a formal partnership of health care providers that creates a circle of care around a patient, in order to improve care for those who have the most complex medical needs. These health care providers are therefore accountable to one another, to the system, and to the patient. The goal of a Health Link is to provide comprehensive and coordinated care to those who experience significant health challenges, in order to improve or maintain their quality of life.

In 2015-16, the Erie St. Clair LHIN continued implementing the Chatham-Kent Health Link, focusing on identifying and connecting patients with coordinated care plans. The main focus of activity was on the development and implementation of technology to improve health care and service-information sharing across provider groups.

The Lambton County Lake Huron Health Link developed a business case that was approved and supported by the ESC LHIN. Work continued on developing partnerships and improving patient outcomes. While this Health Link is in its beginning stages, the LHIN is confident in its ability to address the complex health care needs of those living in the region.

In Windsor/Essex, consultation with providers and a data analysis of high users of the health care system were undertaken in 2015/16. The analysis was performed to determine patients' utilization of ED and acute care services. The analysis also included a geo-mapping, in order to understand why patients prefer to use the health care services available in certain areas of Windsor/Essex.

Community Engagement

Community engagement is both a legislated responsibility and a core function of the LHINs. Local decision-making is the model upon which the LHINs are built. LHINs value the input of community members, health care professionals, and stakeholders to inform their planning and decision-making processes.

ESC LHIN key population and stakeholder groups were targeted to further develop relationships and meet our overall objectives and responsibilities, as outlined in the *Local Health System Integration Act, 2006* (LHSIA). Key population and stakeholder groups included:

- consumers and families of the health care system
- the Francophone community
- Indigenous and Métis communities
- health service providers (HSPs)
- physicians and primary care providers
- allied health care professionals
- public health and social service providers

There was significant engagement during 2015-16 with the Erie St. Clair community, patients and their families, and health care providers. Engagement was related to:

- *Patient's First* consultations
- program-specific engagement, including the Leamington District Memorial Hospital's obstetrics program
- the IHSP 4 development process

Engagement took many forms, including meetings, surveys, interviews, social media postings, website updates, and via email. Ongoing engagement occurred through local provider networks, committees, open board meetings, open mic and online sessions, and formal presentations. Table 5 highlights the ESC LHIN's community engagement activities during 2015-16.

Francophone Engagement

The ESC LHIN remains committed to improving access to health care services in French and bettering the health outcomes of the Francophone population in our LHIN. Throughout fiscal 2015-16, several community engagement and planning initiatives were undertaken by the LHIN so that it could better understand and address the health care challenges faced by Francophones in the region. The ESC LHIN also continued to collaborate with the French Language Health Planning Entity (FLHPE) in Erie St. Clair.

Key initiatives this year included the following:

- The French Language Liaison Committee continued its work, with representation from the Erie St. Clair and South West LHINs and the Erie St. Clair/South West FLHPE. This group meets and works on the deliverables from the joint action plan to support better health care services for local Francophone residents.
- French language and Indigenous data were collected, to better understand local health care needs, as included in the Multi Sector Service Accountability Agreement (M-SAA); this was extended to hospital service accountability agreements (HSAAs) and long-term care home service accountability agreements (LSAAs). Specific requirements regarding the implementation and delivery of French-language services were also included.

- Continued efforts were made to provide support to HSPs to implement French-language services.
- The French Language Services Providers Network continued its work. This group promotes the implementation of French-language services, shares information, identifies collaboration opportunities, and discusses challenges.
- A number of surveys were made available in French to the Francophone population in Erie St. Clair. Survey topics included the IHSP 4, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, and home and community care.
- Focus groups were also conducted with Francophone groups on the IHSP 4, the *Patients First* discussion paper, and on Health Link development in Sarnia.
- Funding was provided to Assisted Living Southwestern Ontario to assist with the supportive-housing needs of local Francophone residents at Résidence Richelieu in Windsor.
- Funding was provided to VON (Victorian Order of Nurses) Windsor-Essex to provide bilingual primary care services at the Langlois Avenue Community Hub in Windsor.
- Two new health service providers were identified as French language-service providers: VON Windsor-Essex and Chatham-Kent Hospice.
- Support was provided for the recruitment and training of two bilingual chronic disease self-management peer leaders through the Windsor Essex Community Health Centre.
- The LHIN and the FLHPE visited the Francophone Adult Day Program in Oshawa to gain insight into its program model and applicability to our region.

Indigenous Engagement

(Note: The term "Indigenous" has been substituted for "Aboriginal" throughout this document.)

Erie St. Clair is home to five First Nations communities, and has a significant First Nations and Métis population living within its urban and rural communities. Ensuring that Indigenous people have equitable access to health care, including culturally safe primary care, remains a priority for the ESC LHIN.

To help improve health care for Indigenous people, the ESC LHIN continues to make investments through engagement with the region's First Nations communities. The LHIN is grateful for the work of the Indigenous Health Planning Committee (IHPC) in guiding and advancing Indigenous health care improvement in the region.

The Erie St. Clair region's IHPC is a planning/coordinating body of decision-makers that is responsible for setting out priorities for the health care needs of the Indigenous communities within the ESC LHIN. The IHPC provides recommendations to the ESC LHIN's senior management and board of directors on Indigenous patient and community health care needs, priorities, systemic barriers, the social determinants of health, community engagement, and integration/coordination opportunities.

The IHPC also offers input on culturally appropriate and effective community-based strategies, including areas of potential investment needed to address health care issues. The IHPC provides these directions in a way that promotes the wellness of current and future generations of Indigenous patients and communities, premised on the concepts of shared control, health equity, cultural inclusion, and holistic (physical, emotional, mental, and spiritual) health.

IHPC members include managers, executive directors, and/or CEOs of Indigenous health service providers that deliver programs and services within the ESC LHIN area; Indigenous health partners; and elders and youth.

Milestones in 2015-16 were reached in a number of areas, including the following.

IHPC

- created a culture-based structural model that outlines the composition of the IHPC, and established an integration model between Indigenous communities and HSPs
- inclusion of elder and youth councils, to provide guidance and leadership to the IHPC
- revised the terms of reference to reflect the IHPC as a planning and vetting body for equal partnership with all ESC LHIN committees and networks
- developed a three-year strategic plan, statistical analysis, and feedback from Indigenous health needs assessment surveys. A total of 641 surveys were collected and 27 community members participated in focus groups
- a task group was formed between the IHPC and the Mental Health and Addictions Network to develop a current-state strengths, weaknesses, opportunities, and threats (SWOT) analysis and to begin addressing the needs that were identified in the joint *South West and Erie St. Clair Local Health Integration Networks Mental Health and Addictions Strategy*
- created an IHPC brochure to promote the IHPC as a vetting body and regional resource
- started a youth suicide focus groups/needs assessments process

Cultural Awareness

- online Indigenous cultural safety (ICS) training was offered by the IHPC to HSPs across the region. To improve culturally appropriate care, ICS training was provided to hospital frontline staff.
- community videos highlighting Indigenous patient experiences in various communities, and a video on traditional healing, were shown across the ESC LHIN
- three "lunch and learns" were conducted for the ESC LHIN staff

Community Engagement

- two presentations were made to the London District First Nation Chiefs Council as an overview of the ESC LHIN and recent developments of the IHPC
- meetings were held with four of the five First Nation Chiefs in the region as well as the LHIN CEO, Senior Planning Director, and board chair, in order to begin relationship building and collaborative health planning based on community needs and priorities
- *Patients First* consultations were completed as requested by each community; a total of five sessions were completed

Health Planning

- hired a full-time Regional Indigenous Health and Strategy Liaison
- hosted the annual pan-LHIN meeting of Indigenous Health Leads, LHIN CEOs, and community representatives
- ensured linkages to palliative care and rehabilitation strategic planning
- planned for the addition of IHPC members to all ESC LHIN committees
- added health equity requirements to LHIN service accountability agreements with providers, including the need to focus on the unique health needs of Indigenous patients

Table 4 outlines key investments made in Indigenous health care in Erie St. Clair during 2015-16.

Table 4: ESC LHIN Investments in Indigenous Health Care, 2015-16

Region	2015-16 Funding
Delaware (via the Southwest Ontario Aboriginal Health Access Centre [SOAHAC])	$115,000, of which $52,000 went toward the funding of: - a mental health worker (based on a pro-rated amount for 2015/2016) - a traditional healer (based on a pro-rated amount for 2015/2016) - a health resource
Windsor/Essex (via SOAHAC)	$60,000, of which $35,000 went toward the Aboriginal Hospice Palliative Care Planning Needs Assessment; and $25,000 toward the set-up of satellite offices in Windsor and Delaware
Windsor/Essex (via SOAHAC)	$63,000 for: - a mental health worker (based on a pro-rated amount for 2015/2016) - a traditional healer (based on a pro-rated amount for 2015/2016) - travel costs - supplies

Community Engagement Initiatives

Table 5: ESC LHIN Community-Engagement Initiatives, 2015-16

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
Governance	11	Open/special board meetings	Governance of ESC LHIN and other matters.	Open board meetings are an opportunity for the public to learn more about local health care.
	8	"Open mic" board meetings	Members of the public can address the ESC LHIN board of directors in an open mic session at each open board meeting.	Relevant issues or questions put before the ESC LHIN board; direct engagement with community members.
	8	Open board meeting highlights	Highlights of information and decisions from open board meetings distributed and posted online.	Increased awareness of board activities and media coverage of important matters.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
LHIN Board to HSP Board Engagement	3	Meetings	Meetings were held in order to develop better communication between the Boards.	Improved communication and relationship building.
Chatham-Kent Community Leaders' Cabinet (CKCLC)	4	CKCLC	Community leaders signed a formal resolution to work together to achieve better health and quality of life for everyone in Chatham-Kent. ESC LHIN CEO Gary Switzer was a Co-Chair of CKCLC.	A new by-law, *Smoke-Free Chatham-Kent*, was implemented by Chatham-Kent Municipal Council in October 2014. The Erie St. Clair Regional Data Consortium was initiated; this program provides a venue for collaboration on local research/data and benefits local service providers and community partners. CKCLC also developed a scorecard and strategic document.
Hospice palliative care/end-of-life care	4	Erie St. Clair Hospice Palliative Care Advisory Council	Identify and recommend ways to improve hospice palliative care, provide advice and recommendations to the LHIN on new programs and initiatives, and strengthen a comprehensive, integrated Hospice Palliative Program in Erie St. Clair.	ESC HPC Network and ESC LHIN *Hospice Palliative Care in Erie St. Clair Strategic Plan* re-fresh published February 2015. Report on Windsor-Essex Community-Based Hospice Palliative Care received September 2015. Overview of new Ontario Palliative Care Network and local leadership communicated October 2015.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	12 (4 per year for each of 3 counties)	Hospice Palliative Care Network	Local engagement to identify service gaps and to plan, coordinate, and review local implementation. Enhance collaboration.	Input into 2015 ESC HPC strategic plan, provincial residential hospice capacity study and provincial advance care planning initiative. Presentation by Network members at the Hospice Palliative Care Ontario conference on the system of integrated palliative care in Sarnia-Lambton.
	2	Hospice Palliative Care/End of Life Care Network Education Subcommittee	Integration and delivery of education in Erie St. Clair.	Education gaps identified, prioritized, and addressed, including education and consultation on policy development specific to advance-care planning and informed consent.
	37 events with nearly 1,100 individuals involved	Educational Collaborative-supported events	Topics to address identified gaps, including advance care planning, etc.	Best practices advanced; consistency in messaging; gaps filled and duplication reduced.
Mental health and addictions	6	ESC LHIN Mental Health and Addictions Network	Responsible for providing high-level strategic counsel to the LHIN to advance system-wide planning, performance oversight for the Leadership Tables, and informed decision-making.	Leadership, monitoring, and oversight of mental health and addiction services, performance, and new funding.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	3	Children and Youth Leadership Table (meetings and focus groups)	Membership includes service providers from school boards, mental health/addictions, Ministry of Children and Youth Services (MCYS), mental health lead agencies, Erie St. Clair CCAC, Schedule One sites, Early Psychosis Programs, etc.	Streamlined transitions in care and strengthened partnerships. Increased networking and overall partnerships.
	14	Behavioural Supports Ontario (BSO) Governance Working Group	A review was undertaken of the Geriatric Mental Health Outreach Teams, Long-Term Care Lead Teams, System Navigators, and internal champions. Process- and outcome-focused.	Care pathways, role clarity and definition; processes for huddles and consultations improved; ongoing engagement is occurring with LTC homes and champions.
	13	Addictions Strategic Plan Steering Committee	The ESC LHIN and local addiction service providers developed a strategic plan for the next three years.	More than 900 individuals helped to inform the addiction plan's recommendations.
	4	Psychiatry Leadership Table	Led by the ESC LHIN Psychiatry Lead, this group is inclusive of the chiefs of psychiatry from the hospitals, as well as community agencies.	Focuses on current issues and spreading best/promising practices.
	1	Suicide Prevention and Education Symposium, "Community, Connection, and Collaboration"	Two-day conference held on September 29 and 30, 2015, focusing on suicide prevention and coordination opportunities to	More than 200 individuals attended. The workshop laid the groundwork for future resources devoted to education, awareness, and

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			build communities of practice.	community development.
ED/ALC	10	ESC LHIN Executive Nurse/Clinical Leaders Advisory Council	An opportunity for organizations to share expert advice and leadership, and to support, enable collaboration, share models of care, and promote best practices with respect to quality and performance improvement.	Shared knowledge, lessons learned, and successes achieved.
	8	ALC Performance Working Group (CCAC-led, LHIN Co-Chair)	To promote and support strategies across the ESC LHIN regions that will ensure persons are living in the most appropriate care setting; optimize system capacity; and avoid and reduce duplication by integrating sectors.	Developed a system that accurately measures, describes, and monitors the current and ongoing ALC situations within the ESC LHIN.
Indigenous	12	Local Indigenous Health Planning Committee	A committee of Erie St. Clair Indigenous health care providers/ organizations and ESC LHIN staff.	Collaboration between the ESC LHIN and Indigenous HCPs working toward identification of priority areas, mental health and addictions strategic plan, and development of a regional health care strategic plan.
	5 focus groups	Part of the engagement work of the *Patients First* discussion paper consultations	Facilitated a discussion on health care needs and services with Indigenous people.	Better understanding of the health care needs of Indigenous populations.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	3 focus groups	Part of engagement to develop the new Indigenous strategic plan	Facilitated a discussion on health care needs and services with Indigenous people.	Participants provided feedback to assist the development of the Indigenous strategic plan.
	1	Development of a needs-assessment survey	Needs assessment survey completed.	There were 641 surveys completed over four sessions; used to research the health care needs of the Indigenous population.
	2 focus groups	Development of mental health awareness with Indigenous people.	Facilitated a discussion on mental health care needs and services with Indigenous people.	Participants provided feedback on mental health services that Indigenous people might need.
	1	Local Indigenous Health Planning Committee	Facilitated a discussion on health care needs and services with Indigenous people.	Better understanding of the health care needs of Indigenous people.
Franco-phone	2	ESC/SW LHINs and FLHPE Liaison Committee	A forum for collaboration and ongoing dialogue amongst the FLHPE, the South West LHIN, and the ESC LHIN in order to improve health outcomes for the Francophone population in these regions.	Partners worked collaboratively to improve access to and accessibility of services in French, with a special focus on priority population groups, including people with mental health and addiction issues, people living with a chronic disease, and seniors and adults with complex needs.
	1	Presentation on serving Francophone	Held November 12, the presentation was part of a training day	Increased awareness and ability of staff of

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
		youth and families	organized by the Child and Youth Mental Health Services Collaborative.	various agencies to serve Francophone youth and families.
	1	Presentation to Lambton County Lake Huron Health Link	The needs of Francophone residents and the importance of providing services in French.	To assist the Health Links committee in its business planning and lead to a community consultation.
		Supported development of Windsor-Essex County Health Unit's breast-feeding app in French	French-language breast-feeding app developed.	To assist local Francophone women and newborns.
	5 focus groups with Francophones	Part of the engagement work of the Health Links strategy, IHSP, and *Patients First* discussion paper consultations	Facilitated a discussion on health care needs and services with Francophones.	Better understanding of the health care needs of Francophones.
	2	ESC LHIN French Language Services Identified and Designated Providers' Network	Health service providers were identified and designated for the provision of services in French, and came together to improve the accessibility of culturally and linguistically appropriate health services for the Francophone population across the LHIN.	Increased knowledge about other HSPs identified and designated to provide French-language services (FLS). They validated the IHSP FLS priories on behalf of the ESC LHIN, and received presentations from Collège Boréal in Windsor on programs and services, from the ESC LHIN on its addiction strategic plan, and from the

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
				FLHPE on its work plan.
Rehabilitation	4	ESC LHIN Rehabilitation Strategic Plan Implementation Committee	Provider and stakeholder-based network providing support for system planning, integration, and implementation.	Worked toward goals outlined in the 2012 *Rehabilitation System Strategic Plan for the Erie St. Clair Region* (improved access, system coordination, effectiveness, and efficiencies).
	6	Sarnia/Lambton Stroke Working Group	Group met to talk about planning, improved patient flow, and community care options.	Advancement of specific care paths for each population.
	7	Access and Restore Working Group	Group met to talk about implementation of the Seniors Mobile Assess & Restore Team (SMART) model of activation in acute care sites, improved patient flow, and reducing ALC days.	Advancement of best practice care for frail and medically complex seniors admitted to hospital.
	1	ESC LHIN Rehabilitation System Evaluation Working Group	Group met to review ESC LHIN rehabilitation system scorecard and alignment to RAC System Evaluation Framework.	Working toward online scorecard accessible to all HSP partners aligned with provincial directions in system evaluation.
	1	Third ESC LHIN Rehabilitative Care Forum, "Introducing a LHIN-wide Geriatric Care Pathway: Implementing an Assess and	Held November 27, 2015, at the John D. Bradley Convention Centre in Chatham. One hundred and thirty HSPs across the care continuum and across the LHIN attended. Keynote	Advanced recommendations on implementation of the five elements of the MOHLTC Assess and Restore Guidelines (October 2014): screening,

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
		Restore approach across the continuum of care"	speaker was Dr. Samir Sinha, Senior Strategy Lead for the MOHLTC. Education and knowledge building: participant engagement in a facilitated discussion on key system elements required to build a comprehensive rehabilitative care approach for community-dwelling seniors experiencing functional decline.	assessment, care planning, care navigation, and transitions home. Key system gaps identified for implementation. Discussed need for increased specialized expertise, integration, and adherence to best practices in the care of older adults, to optimize the maintenance of independence in the community.
	4 meetings and a survey (103 responses) and key informant interviews (53 HSPs and patients and caregivers)	ESC LHIN Rehabilitation System Strategic Planning	Engagement of Rehabilitative Care Committee Health Service Provider partners and key system stakeholders for review and refresh of the 2012 *Rehabilitation System Strategic Plan for the Erie St. Clair Region*.	Developing ESC LHIN rehabilitation system strategic plan
Integrated Health Service Plan	17 focus groups, 230 participants	IHSP 4 engagement sessions through network planning sessions, council meetings, patient advisory committees, and community sessions	These stakeholders met to discuss elements of the IHSP 4: - Rehabilitative Care Committee - Primary Care Council - Patient advisory committees - Health Equity for Newcomer/Immigrants Committee of Windsor-Essex	Provided better understanding of health care needs throughout the region.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			- Executive Nurse/Clinical Leaders Advisory Council - LTC Operators Network - Local Indigenous Health Planning Committee - Mental Health and Addictions Network - Chatham-Kent, Sarnia/Lambton, and Windsor/Essex providers and public sessions	
	1,019 participants	IHSP 4 stakeholder survey; online and paper-based	The online survey was emailed to HSPs/community stakeholders across the region and promoted on the ESC LHIN website and through social media.	Survey responses were analyzed and informed aspects of the IHSP 4.
Patients First: Action Plan for Health Care	430 participants	*Patients First* discussion paper consultations	Facilitated a discussion on health care needs to the following groups: - physicians and NPs - Francophone community - Indigenous communities - HSPs - Primary Care Council	Responses were compiled and sent to the MOHLTC for review.
	400	*Patients First* discussion paper	Seniors' fair	Responses were compiled and sent to the MOHLTC for review.
	130	*Patients First* discussion paper survey	Paper-based and online surveys soliciting feedback on	Responses were compiled and sent to the MOHLTC for review.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			Patients First discussion paper	
Primary care	9	Primary Care Council and Primary Care Tour	A network of primary care providers that advise the LHIN on ways to improve integration and coordination within Erie St. Clair's primary health care system. The Council also focused on ways to increase communication within primary health care providers.	Presentations were provided to all family health teams and CHCs across the LHIN on services and new activities aimed at assisting providers in caring for patients. This also allowed for increased communication between primary care providers and the LHIN.
Quality	4	Quality Council Meetings and Regional Forum	Provided governance, leadership, and oversight for the quality of health care services, to achieve better care, better experiences, and better value for residents of the Erie St. Clair region.	Council work focused on readmissions and work in stroke care.
Orthopaedic	2	Regional Orthopaedic Steering Committee	Improving access to orthopaedic surgery in ESC	Committee work focused on exploring ways to improve access, coordination, and effectiveness of services.
Health Transport-ation	12	Transportation Advisory Group	Regional ESC LHIN-funded health transportation providers met regularly, with the goal of standardization and equitable access to	Implementation of a centralized health transportation program called CareLink.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			health-related transportation.	
Newcomer/ Immigrant health	5	Health Equity for Newcomers and Immigrants (HENI) Committee with local HSPs and settlement/ community agencies	Advanced a future "ideal system model" for newcomer health in Windsor Essex; creation of a care pathway, enhanced collaborations for improved access, gap analysis.	Development of SWOT analysis and service inventory, which will lead to the development of a newcomer/ immigrant patient-care path and action plan.
Syrian Refugee Health Sector Table	4		Discussed provider capacity and how to ensure earliest possible connection to primary care. Coordinated efforts to finalize a capacity review to show availability of existing resources in Windsor/Essex.	Immigrant health clinic created to improve and increase access for all immigrants in Windsor/Essex, and to coordinate health service provision.

Board of Directors

Name	Position	Location	Tenure
Martin Girash	Chair	Leamington	November 20, 2013–November 19, 2016
Michael (Mike) Hoare	Vice Chair	Grand Bend	May 17, 2011–May 16, 2014 March 22, 2012–May 16, 2014 (Order in Council as Vice Chair) November 19, 2014–November 18, 2017 (OIC as Vice Chair) (Re-appointment)
Mike Lowther	Director	Chatham	October 6, 2010–October 5, 2013 October 6, 2013–October 5, 2016 (re-appointment) October 28, 2015 (resignation) November 25, 2015 (revoked)
Barbara Bjarneson	Director	Windsor	February 9, 2011–February 8, 2014 February 9, 2014–February 8, 2017 (re-appointment)
Robert (Bob) Bailey	Director	Amherstburg	April 18, 2011–April 17, 2014 April 18, 2014–April 17, 2017 (re-appointment) January 23, 2016 (deceased)
Joseph Bisnaire	Director	Windsor	June 2, 2011–June 1, 2014 June 2, 2014–June 1, 2017 (re-appointment)
Lindsay (Donald) Boyd	Director	Blenheim	September 8, 2014–September 7, 2017

Ministry-LHIN Accountability Agreement (MLAA)

The MLAA sets out the obligations of the MOHLTC and the ESC LHIN to fulfill its mandate to plan, integrate, and fund local health care services. Developing and updating this accountability agreement is a collaborative process that defines the relationship between the MOHLTC and the ESC LHIN, and helps us strengthen health care in our community (see Table 6).

Table 6: ESC LHIN Report on MLAA Performance Indicators

No.	Indicator	Provincial				LHIN				
		Provincial target	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	ESC % Change 2014/15 to 2015/16	FY 15/16 ESC % Away from Target
Among the LHINs, the ESC LHIN continues to be a stronger performer in CCAC wait times, CT scans, 30-day readmissions, and mental health and substance abuse ED revisits. The most significant opportunities to improve are in the LHIN's ALC days and rate, wait times for MRI scans and knee and hip replacements, and ED length of stay. The ESC LHIN focused on 30-day readmissions through a further review of the data. The process included analysis and sharing of the results with local health service providers, and led to successful outcomes between 2014/15* and 2015/16*: The ESC LHIN rate improved by 6%, and the LHIN is now the best performer in the province. Implementation of the LHIN's mental health strategic plan recommendations have also been sustained, and correlate with the LHIN's mental health and substance abuse revisit performance. In the last two quarters of this fiscal year, the ESC LHIN encouraged collaboration between hospital and community partners to improve the ALC rate in Windsor West. This region has the LHIN's highest rate of ALC. The collaboration between Hôtel-Dieu Grace Healthcare, Windsor Regional Hospital, and the Erie St. Clair CCAC gained momentum, and, in recent months, ALC rates improved, as did the overall ESC LHIN rate in the first quarter of 2016. The ESC LHIN is committed to continually improving local health care, and health system indicators are an excellent way to track results from the system changes the LHIN makes because they are measurable improvements. Implementation of new software systems across all the ESC LHIN hospitals have provided additional resources for scheduling appropriate cases for the LHIN's hip and knee wait times. There are plans to provide further education to orthopaedic office staff on triaging cases based on clinical need.									
	1. Performance Indicators									
1	Percentage of home care clients with complex needs who received their personal	95.00	85.39	86.55	85.28	92.45	88.17	88.54	-4.2	7% off target

	support visit within five days of the date that they were authorized to receive personal support services*									
2	Percentage of home care clients who received their nursing visit within five days of the date they were authorized to receive nursing services*	95.00	93.71	93.21	93.66	95.04	94.48	95.17	0.1	Right on target
3	90th percentile wait time (in days) for CCAC in-home services — application from community setting to first CCAC service (excluding case management) *	21	29	29	30	18	20	18	0.0	14% better than target
4	90th percentile ED length of stay (in hours) for complex patients	8	10.13	10.48	9.97	8.87	10.05	9.67	9.0	20% off target
5	90th percentile ED length of stay (in hours) for minor/ uncomplicated patients	4	4.03	4.28	4.07	4.00	4.22	3.98	-0.4	Right on target
6	Percentage of Priority 2, 3, and 4 cases completed within access target for MRI scans	90.0	41.7	40.3	38.4	33.7	55.1	44.5	32.3	50% off target

7	Percentage of Priority 2, 3, and 4 cases completed within access target for CT scans	90.00	77.77	74.08	74.60	95.06	93.37	94.59	-0.5	5% better than target
8	Percentage of Priority 2, 3, and 4 cases completed within access target for hip replacement	90.00	81.51	79.63	79.97	83.85	77.06	80.24	-4.3	11% off target
9	Percentage of Priority 2, 3, and 4 cases completed within access target for knee replacement	90.00	79.76	78.18	79.14	75.26	85.03	75.94	0.9	16% off target
10	Percentage of ALC days*	9.46	14.35	14.15	14.16	18.07	15.43	16.04	-11.2	70% off target
11	ALC rate	12.70	13.70	14.12	13.98	19.58	17.23	19.50	-0.4	54% off target
12	Repeat unscheduled ED within 30 days for mental health conditions*	16.30	19.62	20.33	20.28	17.05	17.46	17.31	1.5	6% off target
13	Repeat unscheduled ED visits within 30 days for substance abuse conditions*	22.40	31.34	33.39	33.42	25.04	25.25	23.99	-4.2	7% off target
14	Readmission within 30 days for selected HBAM inpatient grouping (HIG) conditions**	15.50	16.60	16.62	16.51	15.51	15.27	14.53	-6.3	6% better than target
	2. Monitoring Indicators									
15	Percentage of Priority 2, 3, and 4 cases completed within access	90.00	87.02	86.56	88.03	85.59	85.79	88.12	3.0	2% off target

	target for cancer surgery									
16	Percentage of Priority 2, 3, and 4 cases completed within access target for cardiac by-pass surgery	90.00	96.01	94.00	95.00	NA	NA	NA	–	–
17	Percentage of Priority 2, 3, and 4 cases completed within access target for cataract surgery	90.00	91.93	87.37	88.09	94.40	87.16	84.60	-10.4	6% off target
18 (a)	CCAC wait times (in days) from application to eligibility determination for LTC home placements: from community setting**	NA	14.00	15.00	14.00	10.00	9.00	9.00	-10.0	–
18 (b)	CCAC wait times (in days) from application to eligibility determination for LTC home placements: from acute-care setting**	NA	8.00	7.00	8.00	7.00	7.00	7.00	0.0	–
19	Rate of ED visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	4.58	12.86	30.57	7.09	19.41	-36.5	–
20	Hospitalization rate for ambulatory care-sensitive conditions	NA	320.78	80.87	235.64	384.49	105.27	298.34	-22.4	–

	per 100,000 population*									
21	Percentage of acute care patients who had a follow-up with a physician within seven days of discharge**	NA	46.09	45.55	46.58	44.12	42.40	44.53	0.9	–

*FY 2015/16 is based on the available data from the fiscal year (Q1-Q3, 2015-16).
**FY 2015/16 is based on the available data from the fiscal year (Q1-Q2, 2015-16).

Operational Performance

The ESC LHIN finished 2015-16 with a small surplus, details of which can be found in our statement of financial activities. Table 7 outlines our funding allocations and operational budget for 2015-16. The statement of financial activities, which follows this table, provides further information on our allocations and budget.

Table 7: ESC LHIN Funding by Sector

Sector	Funding ($ Million)
Hospital	660.1
Long-term care	220.7
Community Care Access Centres	140.5
Mental health	41.6
Community health centres	32.2
Community support services	22.1
Addictions	10.6
Assisted-living supportive housing	11.7
Acquired brain injury	1.5
LHIN operations	6.2
Total for fiscal 2015-16	**$1,147.2 (Billion)**

In 2015-16, the ESC LHIN maintained a staff of 32 employees.

During the year, four individuals served as Professional Leads for the ESC LHIN:

- Dr. Eli Malus, Critical Care Lead
- Dr. David Ng, Emergency Department Lead
- Dr. Martin Lees, Primary Care Lead
- Dr. Tyceer Abouhassan, Endocrinologist Lead

Projects that continue to receive additional funding from the MOHLTC include:

- continued support of the French Language Health Planning Entity
- funding for Indigenous engagement
- continued support for the Critical Care, Primary Care, and Emergency Department Leads

The Chronic Disease and Prevention Management Team continued to focus on diabetes and was responsible for the Diabetes Regional Coordination Centre deliverables. 2015-16 was the Centre's third year under ESC LHIN management.

Management Responsibility Report

The accompanying financial statements of the Erie St. Clair LHIN have been prepared by management in accordance with Canadian public sector accounting principles. The integrity and objectivity of these statements are management's responsibility.

Management is also responsible for implementing and maintaining a system of internal controls to provide reasonable assurance that reliable information is produced. The Board of Directors is responsible for ensuring that management fulfills its responsibilities for financial reporting and internal control, and exercises this responsibility through the Audit Committee of the Board. The Audit Committee meets with management and the external auditors no less than twice a year.

The external auditors, Deloitte LLP, conduct an independent examination, in accordance with Canadian generally accepted auditing standards, and express their opinion on the financial statements. Their examination includes a review and evaluation of the LHIN's system of internal control and appropriate tests and procedures to provide reasonable assurance that the financial statements are presented fairly in accordance with Canadian public sector accounting standards. The external auditors have full and free access to the Performance and Audit Committee of the Board and meet with it on a regular basis.

On behalf of Erie St. Clair LHIN.

Ralph Ganter
Acting Chief Executive Officer

Brady Birkin
Manager, Corporate Services

May 24, 2016

Financial statements of

Erie St. Clair Local Health Integration Network

March 31, 2016

Erie St. Clair Local Health Integration Network

March 31, 2016

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Deloitte LLP
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Independent Auditor's Report

To the Members of the Board of Directors of the
Erie St. Clair Local Health Integration Network

We have audited the accompanying financial statements of Erie St. Clair Local Health Integration Network, which comprise the statement of financial position as at March 31, 2016, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Erie St. Clair Local Health Integration Network as at March 31, 2016 and the results of its operations, changes in its net debt, and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 24, 2016

Erie St. Clair Local Health Integration Network

Statement of financial position
as at March 31, 2016

	2016	2015
	$	$
Financial assets		
Cash	**566,842**	693,831
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 7)	**1,700,855**	5,570,500
Accounts receivable	**48,935**	68,209
	2,316,632	6,332,540
Liabilities		
Accounts payable and accrued liabilities	**548,326**	730,659
Due to MOHLTC (Note 10b)	**93,318**	55,978
Due to Health Service Providers ("HSPs") (Note 7)	**1,700,855**	5,570,500
Due to the LHIN Shared Services Office (Note 3)	**5,474**	3,702
Deferred capital contributions (Note 4)	**287,662**	385,949
	2,635,635	6,746,788
Net debt	**(319,003)**	(414,248)
Commitments (Note 13)		
Non-financial assets		
Prepaid expenses	**31,341**	28,299
Tangible capital assets (Note 5)	**287,662**	385,949
Accumulated surplus	-	-

Approved by the Board

_____ Director

_____ Director

The accompanying notes to the financial statements are an integral part of this financial statement.

Erie St. Clair Local Health Integration Network

Statement of operations
year ended March 31, 2016

	Budget (Note 6)	2016 Actual	2015 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,118,937,656**	**1,141,071,593**	1,142,748,286
Project Initiatives			
Operations of LHIN	**4,347,972**	**4,160,760**	4,325,444
Emergency Department Lead	**75,000**	**75,000**	75,000
Critical Care Lead	**75,000**	**75,000**	75,000
Primary Care Lead	**75,000**	**75,000**	75,000
French Language Health Planning Entities Fund	**425,500**	**425,533**	425,533
Enabling Technologies for Integration Project Management Office	**510,000**	**510,000**	510,000
Diabetes Regional Coordination	**888,328**	**870,561**	888,328
Amortization of deferred capital contributions (Note 4)		**197,063**	163,270
	1,125,334,456	**1,147,460,510**	1,149,285,861
Funding repayable to the MOHLTC (Note 10)	-	**(37,340)**	(55,978)
	1,125,334,456	**1,147,423,170**	1,149,229,883
Expenses			
Transfer payments to HSPs (Note 7)	**1,118,937,656**	**1,141,071,593**	1,142,748,286
General and administrative (Note 8)	**4,347,972**	**4,357,227**	4,473,320
Project Initiatives (Note 9)			
Emergency Department Lead	**75,000**	**73,716**	74,066
Critical Care Lead	**75,000**	**75,000**	75,000
Primary Care Lead	**75,000**	**75,000**	75,000
French Language Health Planning Entities Fund	**425,500**	**390,073**	425,533
Diabetes Regional Coordination	**888,328**	**870,561**	848,678
Enabling Technologies for Integration Project Management Office (Note 3)	**510,000**	**510,000**	510,000
	1,125,334,456	**1,147,423,170**	1,149,229,883
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of this financial statement.

Erie St. Clair Local Health Integration Network

Statement of change in net debt
year ended March 31, 2016

	Budget (Note 6)	2016 Actual	2015 Actual
	$	$	$
Annual surplus			
Prepaid expenses incurred	-	**(31,341)**	(28,299)
Prepaid expenses used	-	**28,299**	29,873
Acquisition of tangible capital assets	-	**(98,776)**	(30,549)
Amortization of tangible capital assets	**160,000**	**197,063**	163,270
Increase in net debt	**160,000**	**95,245**	134,295
Net debt, beginning of year	**(414,248)**	**(414,248)**	(548,543)
Net debt, end of year	**(254,248)**	**(319,003)**	(414,248)

The accompanying notes to the financial statements are an integral part of this financial statement.

Erie St. Clair Local Health Integration Network

Statement of cash flows
year ended March 31, 2016

	2016	2015
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	**197,063**	163,270
Amortization of deferred capital contributions (Note 5)	**(197,063)**	(163,270)
Changes in non-cash operating items		
Due from MOHLTC	**3,869,645**	(5,330,100)
Accounts receivable	**19,274**	2,896
Accounts payable and accrued liabilities	**(182,333)**	(55,346)
Due to MOHLTC	**37,340**	(94,667)
Due to HSPs	**(3,869,645)**	5,330,100
Due to LHIN Shared Services Office	**1,772**	3,411
Prepaid expenses	**(3,042)**	1,574
	(126,989)	(142,132)
Capital transaction		
Acquisition of tangible capital assets	**98,776**	30,549
Financing transaction		
Deferred capital contributions received (Note 5)	**(98,776)**	(30,549)
Net decrease in cash	**(126,989)**	(142,132)
Cash, beginning of year	**693,831**	835,963
Cash, end of year	**566,842**	693,831

The accompanying notes to the financial statements are an integral part of this financial statement.

1. Description of business

The Erie St. Clair Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Erie St. Clair Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSPs") are expensed in the LHIN's financial statements for the year ended March 31, 2016.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Municipalities of Essex, Lambton and Chatham-Kent. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN financial statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Chartered Professional Accountants of Canada ("CPA"). Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. Unspent amounts are recorded as payable to the MOHLTC at period end. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related capital asset recorded.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

Tangible capital assets

Tangible capital assets are recorded at cost. Cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Office equipment	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

3. Related party transactions

LHIN Shared Service Office and LHINC Collaborative

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end is recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

Enabling Technologies for Integration Project Management Office

Effective February 1, 2012, an agreement was formed with Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brant LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from South West LHIN of $510,000 (2015 - $510,000). The LHIN had a contract and retained services of the Transform Shared Service Organization ("Transform"). All funds were expended.

4. Deferred capital contributions

	2016	2015
	$	$
Balance, beginning of year	**385,949**	518,670
Capital contributions received during the year	**98,776**	30,549
Amortization for the year	**(197,063)**	(163,270)
Balance, end of year	**287,662**	385,949

5. Tangible capital assets

			2016	2015
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Office equipment	**855,011**	**705,812**	**149,199**	197,880
Computer equipment	**210,259**	**210,259**	**-**	203
Leasehold improvements	**955,933**	**817,470**	**138,463**	187,866
	2,021,203	**1,733,541**	**287,662**	385,949

6. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the statement of operations reflect the initial budget at April 1, 2015. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $1,141,071,593 is derived as follows:

	$
Initial budget	**1,118,937,656**
Adjustment due to announcements made during the year	**22,133,937**
	1,141,071,593

The final LHIN budget, excluding the HSP funding, of $6,191,854 is derived as follows:

	$
Initial budget	**6,396,800**
Change in funding from the MOHLTC during the year	**(6,170)**
Amount treated as capital contributions made during the year	**(98,776)**
In-Year recoveries by the MOHLTC during the year	**(100,000)**
	6,191,854

7. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,141,071,593 (2015 - $1,142,286) to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2015 as follows:

	2016	2015
	$	$
Operation of hospitals	**660,071,256**	681,438,461
Grants to compensate for municipal taxation - public hospitals	**172,500**	172,500
Long-term care homes	**220,699,564**	211,414,580
Community care access centres	**140,525,653**	138,215,563
Community support services	**22,103,369**	21,234,346
Assisted living services in supportive housing	**11,685,084**	11,567,616
Community health centres	**32,171,091**	31,402,849
Community mental health addictions programs	**12,065,046**	11,751,851
Community mental health programs	**41,578,030**	35,550,520
	1,141,071,593	1,142,748,286

The LHIN receives money from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2016, an amount of $1,700,855 (2015 - $5,570,500) was receivable from the MOHLTC and payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

8. General and administrative expenses

The statement of operations presents the expenses by function. The following classifies general and administrative expenses by object:

	2016	2015
	$	$
Salaries and benefits	**2,930,366**	3,124,200
Occupancy	**358,425**	279,828
Amortization	**197,063**	163,271
Shared services	**313,194**	320,555
Public relations	**53,680**	29,519
Consulting services	**54,584**	53,954
Supplies	**28,001**	25,793
Board Chair per diems	**43,925**	36,575
Board member per diems	**46,550**	26,850
Board member expenses	**49,260**	47,422
Obstetrics expert panel	**4,785**	92,183
Mail, courier and telecommunications	**37,004**	47,739
LHIN collaborative	**38,000**	37,721
Other	**202,390**	187,710
	4,357,227	4,473,320

9. Project Initiatives

The LHIN received funds for various project initiatives reported in the statement of operations. Details of expenses incurred in relation to the Diabetes Regional Coordination Centres are as follows:

	Budget	2016	2015
	$	$	$
Salaries and benefits	**672,720**	**666,710**	638,021
Operating expenses	**215,608**	**203,851**	210,657
General and administrative expenses	**888,328**	**870,561**	848,678

Expenses incurred in respect of all other initiatives were for professional services.

10. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2016 Excess funding	2015 Excess funding
	$	$	$	$
Transfer payments to HSPs	1,141,071,593	1,141,071,593	-	-
LHIN operations	4,160,760	4,160,164	596	15,394
Project Initiatives				
French Language Health Planning Entities Fund	425,533	390,073	35,460	-
Critical Care Lead Fund	75,000	75,000	-	-
Primary Care Lead Fund	75,000	75,000	-	-
Emergency Department Lead	75,000	73,716	1,284	934
Diabetes Regional Coordination	870,561	870,561	-	39,650
Enabling Technologies	510,000	510,000	-	-
	1,147,263,447	1,147,226,107	37,340	55,978

b) The continuity of the amount due to the MOHLTC at March 31 is as follows:

	2016	2015
	$	$
Due to MOHTLC, beginning of year	55,978	150,645
Funding repayable to the MOHLTC related to current year activities (Note 10a)	37,340	55,978
Amounts repaid to MOHLTC during the year	-	(150,645)
Due to MOHLTC, end of year	93,318	55,978

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 33 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2016 was $283,144 (2015 - $272,398) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as at December 2015. Currently, the plan is fully funded.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

12. Guarantees (continued)

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act,* 2006 and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has funding commitments to health service providers associated with accountability agreements. The LHIN had the following funding commitments as of March 31, 2016.

	$
2017	764,626,485
2018	199,068,064

The LHIN also has commitments under various operating leases related to building and equipment, which will be renewed in accordance with standard lease terms. Minimum lease payments due in each of the next five years are as follows:

	$
2017	332,464
2018	332,464
2019	326,164
2020	313,532
2021	309,622

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